STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Optional services provided through the New Jersey Managed Care program

NEW JERSEY CARE 2000+
THE MANDATORY MANAGED CARE PROGRAM

A. DESCRIPTION OF THE PROGRAM

1. The State of New Jersey operates the New Jersey Care 2000+ program, the mandatory managed care program.

2. The objective of mandatory enrollment in managed care is to reduce costs, prevent unnecessary utilization, reduce inappropriate utilization, and assure adequate access to quality care for Medicaid recipients.

3. The basic concept of this program is to enroll Medicaid recipients in MCOs which will provide or prior authorize all primary care services and all necessary specialty services. The MCO is responsible for monitoring the health care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under this program.

   The MCO will assist the participant in gaining access to the health care system and will monitor on an ongoing basis the participant's condition, health care needs, and service delivery. The plan will be responsible for locating, coordinating, and monitoring all primary care and other medical and ancillary services on behalf of recipients enrolled in the plan.

   Recipients enrolled under the program will be offered a choice of at least two managed care entities but will be restricted to receive services included in the program either from the plan or from another qualified provider to whom the participant was referred by the plan. The recipient's health care delivery will be managed by the plan. The program's intent is to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will enhance continuity of care and efficient and effective service delivery.

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4. This State Plan Amendment is authorized under section 1932(a) of the Social Security Act. The mandatory managed care program currently approved will continue to meet all the requirements of sections 1903(m) and 1932.

5. This program will use an enrollment broker to assist eligible individuals in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them. During the enrollment process, the broker will ask beneficiaries about prior physician-patient relationships and help them select the MCO that includes that physician in the network. Information on the beneficiary's prior physician relationship is included on the MCO Plan Selection form. A copy of this form will be forwarded to the selected MCO to ensure continuity.

6. The State will share cost savings resulting from the use of more cost effective medical care with recipients by providing them with additional services.

7. This program is implemented Statewide.

8. This program includes additional benefits such as case management and health education that will not be available to other Medicaid recipients not enrolled in this program. All current benefits provided to beneficiaries under the DDD/CCW 1915(c) waiver program will continue and be provided fee-for-service. Existing case management services provided to beneficiaries under the DDD/CCW 1915(c) waiver will continue in conjunction with additional case management services provided by the MCO.

9. Individuals enrolled in this program are constrained to receive primary care from their primary care provider (PCP) and have specialty care prior authorized by the PCP.

10. For beneficiaries who are Medicaid-eligible through the TANF/AFDC, TANF/AFDC-related program pregnant women and children and parents of eligible children who are eligible under section 1902(a)(10) who the State is otherwise covering under Title XIX enrollment is mandatory. Enrollment is also mandatory for SSI aged, blind and disabled adults who are not dually eligible for Medicare and Medicaid; non-dual New Jersey Care...Special Medicaid Program for Aged, Blind and Disabled beneficiaries; and non-dual beneficiaries participating in the DDD/CCW waiver program. Mandatory beneficiaries who do not select an MCO will be assigned to a managed care plan.

Supersedes 97-20-MA

APR 13 2000

TN 99-14 Approval Date

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11. Enrollment is voluntary for the following:

a. __X__ Children under 19 years of age who are eligible for SSI under Title XIX. This includes special needs children, i.e., children who have complex/chronic medical conditions including physical and developmental disabilities.

b. __X__ Children under 19 years of age who are described in section 1902(e)(3) of the Social Security Act.

c. __X__ Children under 19 years of age who are receiving foster care or adoption assistance who the State is otherwise covering who are eligible under Title XIX State Plan.

d. __X__ Children under 19 years of age who are receiving services through a family centered, community-based, coordinated care system receiving grant funds under section 501(a)(1)(D) of Title V, i.e., children who have birth defects, chronic disorders, developmental delay, or who may be at risk for developmental disabilities. These children are eligible for and identified through the SSI file.

e. __X__ Dual Medicare-Medicaid eligibles.

f. __X__ Indians who are members of Federally-recognized tribes.

12. The SSI and New Jersey Care...Special Medicaid Program ABD individuals, clients of DDD and Division of Youth and Family Services clients may disenroll from an MCO for any reason at any time. For the TANF/AFDC and TANF/AFDC related populations, any selection of or assignment to an MCO (when auto-assignment is necessary) may be changed at the request of the recipient in the first ninety days of enrollment and at least every twelve months thereafter without cause. The recipient may request a change of MCO at any time with good cause. Good cause is defined as:

a. __X__ Failure of the contractor to provide services to the enrollee in accordance with the terms of the MCO contract;

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b. __X__ required Member has filed a grievance with the contractor pursuant to the applicable grievance procedure and has not received a response within the specified time period stated in the contract, or in a shorter time period by Federal law;

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c. __X__ Documented grievance, by the enrollee against the contractor's plan without satisfaction;

d. __X__ Member is subject to enrollment exemption. If an exemption situation exists within the MCO but another MCO can accommodate the individual's needs, a transfer may be granted;

e. __X__ Member has substantially more convenient access to a primary care physician who participates in another MCO in the same enrollment area that contracts with the Department.

13. Medicaid recipients may disenroll from the MCO as follows.

a. __X__ Mandatory enrollees may disenroll for any reason during the first ninety days after the latter of the date the individual is enrolled or the date they receive notice of enrollment and at least every 12 months thereafter without cause. Voluntary enrollees may disenroll for any reason at any time.

b. __X__ Recipients may disenroll from an MCO at any time for good cause.

c. __X__ Recipients may disenroll from an MCO under this mandatory enrollment program because another MCO will be available for re-enrollment.

d. __X__ Recipient disenrollment must be effective no later than the beginning of the first calendar month following a full calendar month after the request for disenrollment is made.

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14. Recipients may be excluded from participation in the mandatory managed care program if they:

a. ___ Have Medicare coverage, except for purposes of Medicaid-only services;

b. ___ Have other insurance;

c. _X_ Are residing in a nursing facility or ICF/MR;

d. _X_ Are enrolled in another managed care entity which does not have a contract with the Department;

e. _X_ Have to travel more than _30_ miles and do not have a choice of two primary care physicians;

f. _X_ Have an eligibility period that is less than 3 months;

g. _X_ Have an eligibility period that is only retroactive;

h. _X_ Are enrolled in a 1915(c) waiver program except the DDD/CCW waiver program beneficiaries that are non-duals;

i. _X_ Are enrolled in a demonstration program;

j. _X_ Are institutionalized, e.g., nursing facility, psychiatric hospital, State institution.

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15. Recipients may be temporarily exempted from participation if they:

a. __X__ Are pregnant women, beyond the first trimester, who have an established relationship with an obstetrician;

b. __X__ Have a terminal illness (hospice definition of terminal illness) and have an established relationship with a physician;

c. __X__ Have a chronic, debilitating illness or disability and have received treatment from a physician and/or team of providers with expertise in treating that illness with whom the individuals have an established relationship (greater than 12 months) and who are not participating in any MCO; and there is no other reasonable alternative as determined by DMAHS at its sole discretion on a case by case basis;

d. __x__ Do not speak English or Spanish and have an illness requiring on-going treatment and have an established relationship with a physician who speaks the same language and there is no available primary care physician in any of the participating managed care plans who speak the client's language;

e. __X__ Have no choice of at least 2 PCPs within 30 miles of their residence.

16. Services not covered under managed care will be obtained in the same manner as under the regular Medicaid program. Medicaid recipients will be informed of the services not covered by the MCO.

17. Preauthorization of emergency and family planning services by the recipient's MCO is prohibited. Recipients will be informed that emergency and family planning services are not restricted.

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18. The MCO may include physician specialists as primary care providers for SSI recipients. A limit on the number of recipients which can be managed by a physician in a plan will be in effect. The State uses geographical access software to evaluate the MCO networks. The geographical access software looks at the distribution of Medicaid beneficiaries in relation to Plan providers. Through the use of this software, the State can map the exact location of Medicaid beneficiaries and providers. The mapping will indicate whether the MCO networks meet the distance and ratio requirements of the contract. The State uses a ratio of 1 FTE Primary Care Physician (PCP) per 1500 members per MCO and 1 FTE PCP per 2000 members, cumulative across Plans.

a. Conditions for Granting Exceptions to the 1:1500 Ratio Limit for Primary Care Physicians.

1. A physician must demonstrate increased office hours and must maintain (and be present for) a minimum of 20 hours per week in each office.

2. In private practice settings where a physician employs or directly works with nurse practitioners who can provide patient care within the scope of their practices, the capacity may be increased to 1 FTE PCP to 2500 enrollees. The PCP must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCP relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCP.

3. In private practice settings where a primary care physician employs or is assisted by other licensed physicians, the capacity may be increased to 1 FTE PCP to 2500 enrollees.

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4. In clinic practice settings where a PCP provides direct personal supervision of medical residents with a New Jersey license to practice medicine in good standing with State Board of Medical Examiners, the capacity may be increased with the following ratios: 1 PCP to 1500 enrollees; 1 licensed medical resident per 1000 enrollees. The PCP must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCP relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCP.

5. Each provider (physician or nurse practitioner) must provide a minimum of 15 minutes of patient care per patient encounter and be able to provide four visits per year per enrollee.

6. Must submit for prior approval by DMAHS a detailed description of the PCP's delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements, 24 hour access system.

7. Must provide information on total patient load across all HMOs, private patients, Medicaid fee-for-service patients, other.

8. Must adhere to the access standards required in the HMO contract with the Department.

9. There will be no substantiated complaints or demonstrated evidence of access barriers due to an increased patient load.

10. The Department will make the final decision on the appropriateness of increasing the ratio limits and what the limit will be.

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b. Conditions for Granting Exceptions to the 1:1500 Ratio Limit for Primary Care Dentists (PCD).

1. A PCD must provide a minimum of 20 hours per week per office.

2. In clinic practice settings where a PCD provides direct personal supervision of dental residents who have a temporary permit from the State Board of Dentistry in good standing and also dental students, the capacity may be increased with the following ratios: 1 PCD to 1500 enrollees per HMO; 1 dental resident per 1000 enrollees per HMO; 1 FTE dental student per 200 enrollees per HMO. The PCD must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCD relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCD.

3. In private practice settings where a PCD employs or is assisted by other licensed dentists, the capacity may be increased to 1 FTE PCD to 2500 enrollees.

4. In private practice settings where a PCD employs dental hygienists or is assisted by dental assistants, the capacity may be increased to 1 PCD FTE to 2500 enrollees. The PCD must be immediately available for consultation, supervision or to take over treatment as needed. Under no circumstances will a PCD relinquish or be relieved of direct responsibility for all aspects of care of the patients enrolled with the PCD.

5. Each PCD must provide a minimum of 15 minutes of patient care per patient encounter.

6. The contractor must submit for prior approval by the DMAHS a detailed description of the PCD's delivery system to accommodate an increased patient load, work flow, professional relationships, work schedules, coverage arrangements and 24 hour access system.

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7. Must provide information on total patient load across all HMOs, private patients, Medicaid fee-for-service patients, other.

8. Must adhere to the access standards required in the HMO contract with the Department.

9. There must be no substantiated complaints or demonstrated evidence of access barriers due to an increased patient load.

10. The Department will make the final decision on the appropriateness of increasing the ratio limits and what the limit will be.

19. In accordance with the MCO's qualifications and requirements, MCOs must (These qualifications/requirements are to be noted in the provider agreement):

a. _X_ Be Medicaid qualified providers and agree to comply with all pertinent Medicaid regulations and State plan standards regarding access to care and quality of services;

b. _X_ Sign an agreement or addendum for enrollment as an MCO which explains the responsibilities;

c. _X_ Meet general qualifications for enrollment as a Medicaid provider;

d. _X_ Provide comprehensive primary health care services to all eligible Medicaid recipients who choose, or are assigned to, the plan;

e. _X_ Refer enrollees for specialty care, hospital care, and other services when medically necessary;